Southwest District Health Client # _____

COVID-19 Vaccination Consent Form

Client Name: _____ Birthdate: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Age: _____ Male Female **Hispanic/Latino** Y N

Race – Circle One: White Black Native American Asian Pacific Islander Other _____

☐☐☐Proof of address verification - DL/ID, UT Bill, Letter with name, ☐ Voucher(employer/org/agency).

PLEASE CIRCLE YOUR ANSWERS

1. Is recipient feeling sick today? …….... No / Yes
2. Ever received a dose of COVID-19 vaccine? ……..... No / Yes / Don't know
   If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Other Product: _____
3. Ever have a severe allergic reaction to an injectable medication? (e.g., anaphylaxis) For example, a reaction for which treatment with epinephrine or EpiPen was needed or for which a hospital visit was required…… No / Yes / Don't know
   - Was the severe allergic reaction after receiving a COVID-19 vaccine?.....No / Yes / Don't know
   - Was the severe allergic reaction after receiving another vaccine or injectable medication? ..No / Yes / Don't know
4. Any known blood disorders or currently taking a blood thinner?..... No / Yes / Don't know
5. Has recipient received passive antibody therapy as treatment for COVID-19?..... No / Yes / Don't know
6. Has recipient received any vaccines in the last 2 weeks? ..... No / Yes
7. Has recipient had a positive test for COVID 19 or has a doctor ever told you that you had COVID 19 in the last 90 days. No / Yes

I have reviewed and answered the questions above, to the best of my ability. I have reviewed the Vaccine Information Fact Sheet. I have voiced my questions and concerns and am satisfied with the answers. I understand the benefits of the recommended vaccine(s). I understand that it is my responsibility to provide up to date information on medical status and that providing incorrect information can be dangerous health wise. I authorize the healthcare staff to perform the necessary health care services, today. Southwest District Health enters all immunization records into the Idaho Immunization Reminder System (IRIS). You may opt out of IRIS at any time by contacting the Idaho Immunization Program.

By signing below, you are authorizing for the COVID-19 vaccine to be administered.

Signature of Patient or Parent/Guardian: _____Today's Date: _____

CLINIC USE ONLY COVID-19 fact sheet given? ☐ Yes ☐ Declined

Final Screener: _____ Vaccinator: _____ Vaccination Date: _____

VACCINE RECEIVED:
☐ Pfizer ☐ 1st Dose ☐ 2nd Dose
☐ Moderna ☐ 1st Dose ☐ 2nd Dose
☐ Janssen ☐ 1st Dose only 1 dose vaccine

Injection Location: □ Left Deltoid □ Right Deltoid

Clinic Site: □ Caldwell □ Emmett □ Payette □ Weiser

□ Other _____ _____

Lot Information:

Expiration date:

NOTES:_____

_____